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AUTHOR Guthmann, Debra
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ABSTRACT

This report provides an overview of chemical dependency, communication barriers, and assessment/treatment considerations for individuals who are deaf or have hearing impairments and have drug or alcohol problems. Following a discussion of the pattern of substance abuse, risk factors, and signs and symptoms, the report describes a model treatment program: the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. The following recommendations for treatment are made: (1) accessible Twelve Step groups are needed; (2) education/prevention services should be provided to individuals who are deaf or hard of hearing of all ages; (3) there is a need for accessible outpatient, inpatient, and after care services; (4) training opportunities about specialized treatment considerations should be offered to professionals working in the field of chemical dependency; (5) more interpreter training programs are needed that offer specialized training in the area of chemical dependency; (6) more chemical dependency counselors are needed who are fluent in American Sign Language; (7) additional research is needed in the prevalence of chemical dependency within the Deaf community; and (8) vocational rehabilitation counselors are needed to work closely with chemical dependency treatment programs. (Contains 13 references.) (CR)

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ED 452 650

Identifying and Assessing Substance Abuse Problems with Deaf, Deafened, and Hard of Hearing Individuals

by Debra Guthmann, Ed.D.

Debra S. Guthmann, M.A., Ed.D is director of the Division of Pupil Personnel Services at the California School for the Deaf in Fremont, CA, and the former director and current project director for a long-term training grant at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. Dr. Guthmann is the current Vice-President of the American Deafness and Rehabilitation Association(ADARA) and the Secretary of the National Association of Alcohol Drugs and Disability(NADD). Dr. Guthmann has developed materials and provided outreach and training activities nationally and internationally regarding various aspects of substance abuse with Deaf and hard of hearing individuals.

Abstract

Professionals who work with Deaf and hard of hearing individuals may encounter clients whom they suspect have a drug/alcohol problem. Limited training is provided to professionals to assist them in identifying what kinds of signs/symptoms would indicate that a client is in need of an chemical dependency assessment and/or treatment. This article will provide an overview of chemical dependency, communication barriers, and assessment/treatment considerations that are unique to this population.

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Jim is a 16 year old student at the School for the Deaf. He started drinking at the age of 13. He drinks every weekend with his friends. He drinks until he gets drunk.

Maggie is a 75 year old retired school teacher. Her husband died a year ago. Since then she has stopped socializing and going to the Deaf Club. She usually drinkgs several glasses of wine in the evening and passes out in front of the TV.

Tim is a college student majoring in counseling. He smokes pot regularly with his deaf friends. He is concerned about the drug testing program they hve started at the post office where he works part time. However, he has continued to smoke pot in spite of his concerns.

Tina is 32 years old, single and has a full time job. She lives with her hearing parents. She uses heroin on a daily basis but snorts it instead of injecting it. She often has difficulty paying her bills.

Tony just lost his job with a computer company where he worked for seven years. He recently ended up in the hospital with

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complications to his diabetes related to an overdose of crack. Legal charges are pending. He has a college degree and a long term relationship with the goal of marriage.

Karen is married. She and her deaf husband have 3 hearing children. She has recently lost interest in her friends and activities. She seems to prefer being alone. A couple of times a month when her husband is out of town, she drinks 3 to 4 wine coolers in an hour. She has experienced blackouts sometimes when she drinks.

Assessment of Substance Abuse

Jim, Maggie, Tim, Tina, Tony and Karen represent some of the many deaf and hard of hearing people in the United States who struggle with issues related to their use of alcohol or other drugs. Like many other members of the deaf and hard of hearing communities, their lives have started to be negatively impacted by their use of mood altering chemicals. As professionals who encounter deaf and hard of hearing individuals as we provide services, we may work with individuals like those described above. Their use of alcohol or other drugs may interfere with their ability to function and be productive and contributing members of society. For some, the chemical use may be so severe that it threatens their health, their famiiesy, their work and, ultimately, their lives. How can professionals serving deaf andhard of hearing people, determine the extent of a person's use of mood altering chemicals and recommend appropriate services in response? This is the goal of a process known as assessment.

According to the 1996 *National Household Survey on Drug Abuse* (Substance Abuse and Mental Health Services Administration, 1996), about 74 million Americans age 12 years and older have used drugs in an illegal manner one or more times. Such activity has the potential to interfere with the daily routines, relationships, and health of the user. Addiction to alcohol and

other drugs is found in every class and group in the United States, including deaf and hard of hearing people. How does one know if someone is addicted? Can a person who only drinks beer be addicted? If someone only drinks on the weekend, is that person alcoholic? Professionals who work with deaf and hard of hearing individuals must be familiar with how to identify the basic signs and symptoms of substance abuse.

The Definition of Chemical Dependency

Chemical dependency can be defined as the continued use of mood-altering chemicals, despite harmful consequences and without the ability to stop or control the use. It is a primary love relationship with a mood altering chemical that systematically changes the way a person thinks, feels and behaves. Using drugs becomes more important than interpersonal relationships, performance at school or work, planning for the future, or anything else. Evans (1990), reminds us that Father Martin, a famous priest in the addictions field, describes the criteria for identifying alcoholism simply as, "What causes problems is a problem." If drinking and using drugs are causing problems in someone's life and the individual keeps drinking and using drugs in spite of the problems, then that person has a problem with drugs and alcohol. From the examples at the beginning of this paper, Tim may serve to illustrate some of these points. Although he is concerned about the drug testing program at work, he has not stopped his use of pot. Therefore, it appears that his use of marijuana may be more important to him than his employment. Maggie may also show us how the use of alcohol to deal with problems instead starts to create problems. Maggie may have started to use alcohol as a way of coping with her grief. Now, however, her drinking and passing out may be a threat to her health and safety.

There is substantial evidence that chemical dependency can be accurately described as a

disease. In fact, "The American Medical Association, American Psychiatric Association, American Public Health Association, American Hospital Association of Social Workers, World Health Organization, and the American College of Physicians have now each and all officially pronounced alcoholism as a disease (Valiant, 1983). In April of 1987, the American Medical Society on Alcoholism and other Drug Dependencies (whose membership includes over 2,000 M.D.s certified as specialists in chemical dependency) officially declared that what is true for alcoholism is also true for addiction to other drugs (Schaefer, 1996).

Chemical Dependency is a *primary* disease meaning that it is not just a symptom of some other underlying physical or emotional disorder. Instead, it causes many such disorders. This means that many other problems a chemically dependent person may have - such as physical illness, disturbed family relationships, depression, unresolved grief issues and trouble at school or on the job - cannot be treated effectively until the person stops using chemicals. The dependency must be treated first.

Chemical Dependency is a *progressive* disease and once a person enters the addiction process, the disease follows a predicable progressive course of symptoms. Left untreated, it always gets worse. The progression typically starts with a person using chemicals with few consequences and moves to the use of chemicals with more serious consequences.

Chemical Dependency is a *chronic* disease. This means that there is no cure for this condition. In this respect, chemical dependency is similar to diabetes, another chronic disease. In both cases, an individual can have a healthy, happy, and productive life as long as he or she accepts the need for a program of recovery. For the chemically dependent person, this means no use of mood-altering chemicals and other changes in one's lifestyle. Chemical dependency is a

lifelong disease with effective treatment, but no cure.

Chemical Dependency is a *fatal* disease. A chemically dependent person ultimately dies prematurely if he or she continues to use alcohol or other drugs. According to Schaefer (1996), the average lifespan of an alcoholic is 10 to 12 years shorter than that of a non alcoholic. He also states that alcoholics are 10 times more likely than non-alcoholics to die from fires, 5 to 13 times more likely to die from falls and 6 to 15 times more likely to commit suicide.

The four characteristics of chemical dependency described (primary, progressive, chronic and fatal) can be discouraging for both the addicted person and others who want to help. But, chemical dependency can be treated and arrested. Schaefer (1996), indicates that seven out of ten chemically dependent persons who accept treatment and use the knowledge and tools they are given there find sobriety.

The Pattern of Alcohol/Drug Use

As indicated with the scenarios of Jim, Maggie, Tim, Tina, Tony and Karen, addiction doesn't happen overnight and people start to use for a variety of reasons. Most of the time, people begin to drink or use other drugs to have a good time. For some people, their use of alcohol or other drugs doesn't stop there. The pattern of addiction consists of four different stages which include: Use, Misuse, Abuse and Dependency. 1.) *Stage One - Use* - A person uses alcohol and or other drugs in a way that does not cause problems in everyday life, for their family, for their friends or for society(community); 2.) *Stage Two - Misuse* - A person uses alcohol or other drugs and the alcohol and/or other drugs causes problems for them. These problems can happen at home, school or work and can involve the family, friends and/or the police; 3.) *Stage Three - Abuse* - A person thinks or feels that he/she needs the alcohol and/or

other drugs to feel good, to go to work or school, to solve problems, to socialize with friends, etc.; 3.) *Stage Four - Dependency(Addiction)* - A person needs to use alcohol and/or other drugs, just to feel normal. These individuals have many problems but don't see them. These individuals cannot stop their use of alcohol and/or other drugs without some level of intervention.

The Diagnostic criteria for chemical dependency may include several or all of the following items: continued use despite negative consequences, pathological use, loss of control, use to extreme intoxication, blackouts, increased tolerance, preoccupation with use, polydrug use, intoxication throughout the day, repeated attempts to quit/control use, binge use, solitary use, failure to meet obligations due to use, use to medicate feelings, unplanned use, protecting supply, changing friends, willingness to take increasing risk, morning use or tremors.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) is widely used to "provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat people with various mental disorders" (DSM-IV, 1994, p. xxvii). There is an entire section dealing with substance-related disorders which presents diagnostic options for various substances and for abuse or dependence. The DSM-IV criteria for alcohol dependence include a maladaptive pattern of alcohol use; increased tolerance; characteristic withdrawal symptoms; inability to cut down or stop; giving up or reducing social occupational or recreational activities because of drinking; time spent focused on drinking or obtaining alcohol; and continued drinking despite physical or psychological problems caused by the use of alcohol. Diagnosis or assessment of a substance abuse problem may happen in a variety of settings including a medical

setting, a substance abuse treatment program, a funding agency or a mental health services provider.

Risk Factors

Many Deaf and hard of hearing young people grow up in families and attend schools where their language isolates them from the normal information flow. The availability of information on substance abuse and treatment is fragmentary, haphazard and slow. Essential to prevention, assessment and treatment is having materials and approaches to these chemical dependency topics. For those persons who use ASL or another manual language, it is necessary that these materials and approaches are presented in ways that are readily processed. Currently, the written and visual materials that address this knowledge gap are inadequate and often written at a level the Deaf child cannot understand. Those that are available are not systematically distributed or used.

Deaf adolescents may experience a higher level of stress in their lives than adolescents who can hear. As a result, these adolescents may turn to drinking and drug use to reduce stress and/or fit in with hearing students and peers. Unfortunately, very few studies have been conducted to identify the variables that predict drinking and drug use among deaf adolescents. Dick (1996) found the following school and peer related variables to be predictors of Deaf and hard of hearing adolescents' use of alcohol and marijuana: 1.) School grades were the most salient predictor of marijuana use and respondents with poor grades used marijuana more frequently than those with higher grades; 2.) Deaf and hard of hearing adolescents who attended main-streamed schools and had high numbers of hearing friends at school reported higher rates of alcohol use than those with smaller numbers of hearing friends at school. From

the example individuals, Jim's situation is appropriate to consider here. The information we have about Jim is sketchy but more investigation into Jim's background may show some of these risk factors to be present and possibly contributing to his drinking patterns.

Assessment Issues

The purposes of chemical dependency assessment are to evaluate an individual's strengths, problems, needs and develop a treatment plan (CSAT-ASAM, 1995). While assessment has always been an important aspect of appropriately serving clients, the burgeoning of managed care systems, with conservative approaches to placing people in treatment, make accurate assessment even more crucial.

When assessing the extent of an individual's chemical use the quantity of chemicals used should not be the sole basis for a diagnosis. In the examples of the individuals at the beginning of the paper, the quantity of their use alone is not very helpful. Karen, for example, only drinks a few drinks a couple times a month. If quantity is the only indicator used to diagnose a problem, it would appear that her use is not serious. However, when one considers that she may be drinking when she is responsible for the care of her children, the situation appears more serious. As in this instance, the quality of use also provides helpful indicators of dependency. The development of increased tolerance or the presence of withdrawal symptoms are considered indicators of dependence. The element of loss of control is also recognized as significant in assessing chemical dependency. The individual who uses more than planned or violates his/her own limits for use may be experiencing a loss of control. As previously mentioned, another factor considered to indicate dependency is the continued use of mood altering chemicals despite knowledge of negative consequences. Individuals who seek to resolve their problems through

the use of alcohol and other drugs end up with even more problems because of their use.

For diagnostic purposes, most agencies that work with Deaf and hearing individuals have developed their own assessment protocols, which seek to eliminate the communication barriers inherent in diagnostic tools developed for use with hearing people. The following elements, consistent with the biopsychosocial perspective, should be included in a model assessment: medical examination, alcohol and drug use history, psychosocial evaluation, psychiatric evaluation (where warranted), review of socioeconomic factors, review of eligibility for public health, welfare, employment and educational assistance programs" (CSAT, 1995, p. 66).

Signs and Symptoms in Life Areas

One way of assessing the impact alcohol and other drugs have on a person's life is to consider the consequences of that use in various life areas. These life areas may include school/employment, family, social, physical, legal, spiritual, financial and the impact that substance abuse has had on each area. Generally, the primary difference in assessing Deaf and hard of hearing individuals as compared to the assessment of hearing people relates to communication issues. Unfortunately, there are currently no formalized assessment tools specifically designed for use with Deaf persons. As mentioned previously, programs serving Deaf people have tended to develop their own systems or have modified existing instruments normed on hearing people. The process typically incorporates a structured interview model focusing on major life areas. The following are some of the consequences commonly seen in the respective life areas:

Physical
frequent, unexplained illness
sudden weight loss or gain

Financial
overdue bills
banking problems

injuries (from fight, accidents)
generally unhealthy appearance
unusual sinus or dental problems
memory loss (blackouts)
hangovers

borrowing/stealing money
owing money to others
gambling activity
unexplained sources of income

Family
fights, disagreements (about use)
neglect of responsibilities
failure to attend family functions
lack of trust
separation/divorce
loss of custody of children

Work/School
unexplained absences
pattern of absences/tardiness
inconsistent/declining performance
under the influence of chemicals
problems with boss/co-workers
discipline in job/school

Legal
DWI or DUI charges
probation violations
restraining orders
legal fines
court appearances

Social
isolation, lack of friends
changing friends
socialization centered on use
friends are older or younger
broken relationships

These signs can help to detect a problem with the use of alcohol or other drugs. One or even a few of these symptoms alone is probably not significant but in combination, they can point to difficulties. Changes in these life areas that are not attributable to other causes may be significant factors when considering whether or not a person has alcohol or other drug problem. The above information should be used as a guide with collateral information becoming critical when attempting to determine the need for chemical dependency treatment or other interventions.

Communication Issues and Assessment

When Deaf or hard of hearing individuals are in need of a chemical dependency assessment, often they are interviewed by a hearing person who is not fluent in American Sign Language. There have been incidents where an assessor attempts to complete the interview process by writing back and forth to the Deaf person or expecting him/her to read lips. Both of

these approaches are unreliable as well as being culturally and ethically inappropriate! This is due in part to the fact that Deaf or hard of hearing individuals being assessed may not be familiar with the language used by the assessor. If the assessor is not fluent in ASL, an interpreter needs to be used to effectively convey communication during the interview process. The addition of a third party will most likely change the dynamics of the assessment and possibly the validity of the interview session if the interpreter is not fully qualified. There are few interpreter training programs in the United States that focus on the specialized substance abuse vocabulary necessary when assessing Deaf and hard of hearing individuals. It is imperative that any assessor utilizing an interpreter makes sure to use a fully certified and qualified interpreter.

A common problem encountered when assessing Deaf people involves the use of chemical dependency language not familiar to the individual. For example, a typical question may deal with the experience of a "blackout" which is a significant diagnostic feature of chemical dependency. (Blackout refers to a period of time in which the person is awake and functioning but after which there is no recollection of some or all of the events.) In assessing a Deaf client, the interviewer may need to explain the phenomenon in addition to (or instead of) using the term "blackout". The interviewer who fails to explain concepts or vocabulary that may be unfamiliar risks compromising the validity of the assessment. Few clients will ask for an explanation or clarification of terminology, but instead may respond to the question without understanding it completely.

Treatment Considerations

Demographic information indicate that 6% of the general population is considered to be hard of hearing with one out of every 14 individuals identifying themselves as having difficulty

hearing (Schein, 1974). If Deaf people represent one half of one percent of the U.S. population, there should be 4,000 Deaf people in drug or alcohol treatment on any given day (McCrone, 1994). There appears to be no evidence of this occurring.

Often a Deaf or hard of hearing person is admitted to a treatment program designed to serve hearing people and is provided access to that program via the services of sign language interpreters. When Deaf clients are mainstreamed with a group of hearing patients, they may not be able to express themselves articulately enough to communicate clearly with different individuals and the group. If a sign language interpreter is not available, the leader of the group may try to communicate with the person through pencil and paper, trying to explain some of the issues. Without the presence of the interpreter, the deaf individual misses out on all the information shared during the therapeutic group and may get feedback from their facilitator that they were not paying attention or that they only hear what they want to hear. Most of the time an interpreter is not provided 24 hours a day but is only made available to the client on a very limited basis. The absence of an interpreter precludes Deaf and hard of hearing individuals equal access to staff as well as severely restricting their interactions with other clients (i.e. meal times, free time, etc.) Such interactions are a key part of the treatment process. The optimal placement for Deaf and hard of hearing individuals is with staff who are fluent in ASL and sensitive to Deaf culture.

The most therapeutic process of treatment is not necessarily the groups and lectures, but rather the interaction and fellowship that occurs among peers in their free time. Deaf and hard of hearing clients often feel that they miss out on this interaction and fellowship. When Deaf clients must depend solely on the support of interpreters, the sense of bonding is vague and the

emotional impact is usually lost because interaction is through a third person. Sometimes an interpreter is unfamiliar with chemical dependency treatment and recovery language. The stage of recovery can be highly emotional, stressful and very intense. When misinterpretations occur, it becomes frustrating for all involved and can even on occasion be harmful to the client. Interpreter training programs need to add vocabulary related to chemical dependency to their already existing curricula.

A Model Program

There are very few substance abuse treatment programs that are designed specifically to work with Deaf and hard of hearing individuals. One of these programs is the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals(MCDPDHHI). This program utilizes a 12-step philosophy and uses treatment approaches that are provided by a staff fluent in ASL and knowledgeable about Deaf culture. The MCDPDHHI currently receives federal funding from the Department of Education to provide training in the area of substance abuse and Deafness to professionals on a national basis. From 1990-95, this Program received federal funding from the Center for Substance Abuse Treatment to develop a model program (Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, 1994). Instead of utilizing primarily reading and writing in treatment, language barriers are removed by focusing on the use of drawing for treatment assignments. All written materials have been modified to meet the individual needs of the client and video taped materials are presented using sign language, voice and captioning. The Program also provides complete access to all clients by utilizing assistive listening devices, TTY's(telecommunication devices for the Deaf), flashing light signals and decoders.

Guthmann (1996) studied the treatment outcomes of 100 individuals who completed treatment at the MCDPDHHI. The clients were followed for one year following treatment to determine which variables had the greatest impact upon treatment outcomes. The study found that the variables having the greatest impact on the ability to maintain sobriety after treatment completion were attendance at Twelve Step meetings, the ability to talk to family about sobriety and being employed. Of Deaf and hard of hearing clients entering the MCDPDHHI, 75% were unemployed and the research indicated that there was a strong relationship between abstinence and employment. There is a need to make vocational rehabilitation a strong component of inpatient treatment and the aftercare that follows. In the study that was completed in 1996, Guthmann found similarities in the characteristics of what contributes to overall success in recovery for Deaf, hard of hearing and hearing individuals. This indicates that if the chemical dependency treatment provided to a Deaf and hard of hearing individual is accessible, the variables that are necessary to maintain sobriety are similar in the hearing and Deaf populations.

Phase I: Evaluation/Assessment

At the MCDPDHHI, treatment is provided in three phases. Phase I is the evaluation/assessment phase, during which time various assessments are used to gain an understanding of the client and his/her use of mood altering chemicals. The assessment includes data on the client's medical background, a social history, a chemical use history, a clinical assessment and a communication assessment. The communication assessment is an important tool which profiles a client's communication preferences and needs and facilitates the provision of treatment and support using the client's preferred method of communication. During Phase I, clients also complete a drug chart assignment in which they detail through the use of drawings,

the different drugs they have used, a description of their last use and examples of consequences of their use in major life areas such as physical health, legal, family, social, work/school and financial. With few exceptions, drug chart work, and many other assignments, are done through drawing. The use of drawing removes the barrier created for many deaf people by the English language. It also encourages clients to be in touch with their experiences and, as a result, more in touch with the feelings connected to those experiences.

Phase II: Primary Treatment

During the primary treatment phase, clients receive education about the Twelve Steps and complete step-related assignments. Ideally, clients will complete Steps One through Five while in primary treatment. The goal of this phase-for clients to integrate the concepts behind the Twelve Steps into their recovery-is more important than the number of Steps completed. The typical Step work assignments used by programs for hearing persons have been modified to meet the needs of the clients at the MCDPDHHI. For example, clients will draw pictures of their experiences related to particular steps that they present in therapeutic groups with staff and peers. Most often, clients present their work using American Sign Language and rationale developed by the treatment staff for various portions of step assignments help to identify the objectives of each assignment and determine if the client has met the objective.

Beginning in Phase I and continuing throughout the client's stay, involvement in Twelve Step meetings is provided as well as education about the programs of Alcoholics Anonymous, Narcotics Anonymous and other Twelve Step groups. A family week experience is provided for clients and their families as appropriate whenever possible. Often, family members are not fluent in sign language and for the first time, through the use of an interpreter, the family explores a

variety of issues. If family members are unable to attend, materials and phone contact with staff is available to all family members.

The MCDPDHHI uses a behavioral approach with clients which includes education and support designed to help individuals identify and correct self-defeating behaviors. Levels of intervention for negative behaviors are specific to the client's behavior, and are modified if the behavior escalates. Clients are given the opportunity to learn, practice, and integrate skills developed in treatment. An initial intervention would typically be a one-to-one discussion with the counselor and often this helps the client recognize and change the behavior. If the behavior continues or becomes worse, a behavior contract might be an appropriate second-level intervention. Various approaches may be devised based on the individual needs of the client and each approach becomes part of the client's individual treatment plan.

Behavior contracts may be used when behavior becomes inappropriate or negatively affects the treatment process in some way. Behavior contracts may be utilized for incidents such as: the violation of unit rules, arguing about staff directives, failure to complete work on time, failure to focus on treatment or focusing on the needs or issues of other patients. Behavior contracts are not used as punishment and should specify the behaviors for which they are being given as well as the changes that are expected.

Another behavior management technique utilized while clients are in treatment is the Probation Contract. Probation contracts may be used to help a client recognize behaviors which seriously threaten the success or quality of his/her treatment experience. It is used as a follow up to a behavior contract in the event that the client does not respond positively or is openly defiant to the terms of a behavior contract. Probation contracts again specify expected changes in the

clients behavior, and may also include an assignment which helps the client identify and change his/her behavior. Failure to adhere to the probation contract may result in the client being asked to leave the program.

Phase III-Extended Care/Aftercare

Phase III includes an optional extended care/aftercare program for those clients who need additional support in transitioning back into the community and an aftercare component. For clients who come from outside Minnesota, staff members attempt to set up a comprehensive aftercare program in the client's home area, offering education and support to service providers there. For local clients, the Program offers individual aftercare sessions as well as an aftercare group and connects clients to other local resources such as Twelve Step meetings, a Relapse Prevention group, therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources of assistance and support. Networking with other service providers both locally and nationally is an important activity related to aftercare. Aftercare for clients residing in states other than Minnesota continues to be a challenge. There are limited Twelve Step meetings that currently provide interpreters in some major metropolitan areas, let alone rural communities. Shortages of professionals trained to work in this discipline exist on a national basis. Developing an aftercare plan for out of state clients might be compared to putting together a puzzle--sometimes with many of the pieces missing. In this phase, Steps Six through Twelve are discussed, and assignments similar to the format described previously in this section are given to the clients.

Relapse prevention may be addressed in primary treatment, or in later stages of treatment such as aftercare/extended care. It is important to understand that relapse is a process of

changing behaviors that culminates in the return to using mood altering chemicals. Clients are offered information about warning signs of relapse in terms of feelings, behaviors or environment. Clients are taught to recognize and respond to warning signs in ways that are likely to support ongoing sobriety.

Obstacles to Treatment and Recovery

The Deaf and hard of hearing community is a small, closeknit group who tend to view substance abuse very negatively. If you have a 'bad habit' you are perceived as a 'bad person' who puts the well-being and public image of the group in jeopardy. This shame interacting with the cultural, linguistic and educational isolation of Deaf and hard of hearing people, leads to reluctance to acknowledge drug and alcohol abuse. There is a negative stigma associated with those individuals in the Deaf community who are addicts.

Another problem encountered is the "deaf grapevine" within the Deaf and hard of hearing community. The idea of confidentiality is less cherished among Deaf and hard of hearing individuals than it is among the hearing. The relationship of confidentiality and its importance to recovery is almost as difficult to comprehend and accept as the concept that addiction is a disease which is treatable. Thus, the grapevine serves to reinforce the addicted individual's need to keep his or her problem a secret.

When a Deaf or hard of hearing person completes treatment, there are few recovering individuals fluent in ASL or Deaf and hard of hearing that are capable of being sponsors. When thinking of reaching out for help, confidentiality is a fear and a concern. This lack of a sense of community makes Deaf and hard of hearing people feel even more isolated. If confidentiality cannot be respected within a small closeknit community it makes Deaf and hard of hearing

people more apprehensive of the outside world.

The major problem faced by Deaf and hard of hearing substance abusers as well as by Deaf and hard of hearing people in general is communication. AA's basic slogan, "Call before you pick up your first drink," poses a real problem for Deaf and hard of hearing addicts. Only a limited number of treatment programs have accessible telephones(telecommunication devices/ TTY's) and few treatment centers own this equipment. Moreover, this may threaten the confidentiality and the integrity of the therapeutic relationship. Interpreters are often mistrusted either because of preconceptions, because they are hearing or because the interpreter is known to the client.

A common suggestion in recovery is to avoid old acquaintances (people, places and things) that provided reinforcers for the substance abuse. Their circle of Deaf and hard of hearing friends is limited; therefore, they will have a tendency to associate with previous friends who may still be using chemicals or be placed in the same stressful situations again, putting the client at risk of returning to a life of chemical dependency. Many Deaf and hard of hearing people, attempting recovery, will relapse because of loneliness.

There is also a lack of options in recovery related programs, services and opportunities for Deaf and hard of hearing people. Only a few chemical dependency related services, programs and self-help groups are available that are accessible through interpreters. This compares to countless numbers of services and programs that are freely accessible to all those who are hearing and non-disabled. The Americans with Disabilities Act(ADA) which was passed by the legislature a few years ago, was important because it prohibits discrimination in state, local and private sector services whether or not these programs get federal funding. Title III of the ADA

prohibits discrimination against people with disabilities in privately owned public accommodations such as private drug and alcohol treatment facilities. Obviously, despite this act, discrimination occurs every day to Deaf and hard of hearing people since needed services are primarily offered in settings that are not fully accessible.

Conclusion

In order for Deaf and hard of hearing individuals to have a reasonable chance of being successful in a recovery program, a number of things must first occur: 1.) there is a need for accessible Twelve Step groups; 2.) education/prevention services should be provided to Deaf and hard of hearing persons of all ages; 3.) there is a need for accessible outpatient, inpatient and aftercare services; 4.) training opportunities about specialized treatment considerations should be offered to professionals working in the field of chemical dependency; 5.) more interpreter training programs are needed that offer specialized training in the area of chemical dependency; 6.) there is a need for more chemical dependency counselors who are fluent in American Sign Language; 7.) additional research is needed in the area of chemical dependency and the prevalence within the Deaf and hard of hearing community; 8.) and there is a need for vocational rehabilitation counselors to work closely with chemical dependency treatment programs.

Deaf and hard of hearing individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for chemical dependency, since treatment efforts are typically not grounded in culturally specific knowledge. Ideally, individuals who successfully complete a alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober

living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible Twelve Step meetings. This kind of environment is unavailable for the majority of Deaf and hard of hearing individuals. Because Deaf and hard of hearing people make up a low incidence population, professionals and the recovering community need to work together on a state, regional and national basis to make sure that accessible services are being provided for Deaf and hard of hearing individuals.

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